TN 98-12
STATE PLAN AMENDMENT EXHIBITS
INPATIENT ACUTE HOSPITAL

Exhibit 2:
C. 147 of Acts and Resolves of 1995

Chapter 147

Boston Public Health Act of 1995

AN ACT RELATIVE TO PUBLIC HEALTH IN THE CITY OF BOSTON.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Spec L c. 570 § 1

SECTION 1. (a) It is hereby declared for the benefit of the people of the city of Boston, in order that there be an increase in their welfare and an improvement in their living conditions, it is essential that a new public health care system be established for the city of Boston that can meet the challenges of a rapidly changing health care environment and ensure the continuous delivery of quality health care to the residents of the city; that the new public health care system must be able to coordinate outreach, health education, prevention, outpatient, home care, emergency, inpatient, specialty, aftercare, rehabilitation, and long term care services in order to create a comprehensive and integrated continuum of care with the goal of promoting health and well-being, meeting the medical and public health needs of all served and of educating future physicians and caregivers; that a new public health commission be created in the city of Boston as the successor to the city's department of health and hospitals in order to better administer, enhance and expand the public health services provided by the city; and that the city's new public health care system should consist of a network of health care providers joining the city's traditional public health services and facilities with private hospitals, community health centers and other associated community based organizations and providers.

(b) It is hereby further declared for the benefit of the people of the city of Boston that the city should be empowered to provide for the establishment of a new medical center as the centerpiece of the city's public health network to be composed of Boston City Hospital, Boston Specialty and Rehabilitation Hospital and a private, nonprofit hospital; that the mission of the new medical center, in partnership with the city's public health commission, community health centers and other community based providers, shall be to consistently provide excellent and accessible health care services to all in need

of care, regardless of status or ability to pay; that recognizing the historic mission and commitment of Boston City Hospital to the public health needs of all residents of Boston, the new medical center shall have a continued commitment to the urban population, to vulnerable populations within the city, including those residents of the city who are underserved by existing health care services, and to other communities served; that the new medical center shall play an important role as a referral, tertiary level hospital serving the region in a financially responsible manner and continue to serve the most acutely ill patient populations; and that in the conduct of this mission, the new medical center shall commit itself to six equally important guiding principles: (1) ensuring the availability of a full range of primary through tertiary medical programs, in addition to a commitment to public health, preventive, emergency and long term rehabilitative care programs; (2) serving both urban and suburban communities in a culturally and linguistically competent manner that strives to meet the current and changing health care needs of people of all races, languages, cultures and economic classes; (3) providing a high degree of medical, nursing, management and technical competency and accountability; (4) enhancing its role as a major academic medical center, including support for bio-medical, public health, medical education and basic science research; (5) providing managed care services to the communities served by the new medical center and participating effectively and competitively in managed care plans serving the patient population; and (6) treating its patients, staff and the communities served with respect and dignity.

Spec L c. S70 § 1

This act may be referred to and cited as the Boston Public Health Act of 1995.

SECTION 2. As used in this act the following words shall, unless the context otherwise requires, have the following meanings:-.

Spec L c. S70 § 2

"Board of health and hospitals", the board of health and hospitals of the city established pursuant to chapter six hundred and fifty-six of the acts of nineteen hundred and sixty-five.

"Boston City Hospital", the hospital located in the city provided for by chapter one hundred and thirteen of the acts of eighteen hundred and fifty-eight under the care and control of the department of health and hospitals, and all branches thereof heretofore or hereafter established, and all other

TN 98-12
STATE PLAN AMENDMENT EXHIBITS
INPATIENT ACUTE HOSPITAL

Exhibit 3:
Transfer Matrices

TRANSFERRING RULES- WITHIN A HOSPITAL

MANAGED CARE RECIPIENT

FROM: TRANSFERRING UNIT	TO: RECEIVING UNIT: MED SURG	TO: RECEIVING UNIT: ** PSYCH	TO: RECEIVING UNIT: SUB\ABUSE
MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE
** PSYCHIATRIC	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE
SUBSTANCE ABUSE	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE
MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE
** PSYCHIATRIC	TRANSFERRING UNIT:* NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE
SUBSTANCE ABUSE	TRANSFERRING UNIT:* NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE

NON-MANAGED CARE RECIPIENT

FROM: TRANSFERRING UNIT	TO: RECEIVING UNIT: MED SURG	TO: RECEIVING UNIT: ** PSYCH	TO: RECEIVING UNIT: SUB\ABUSE
MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
** PSYCHIATRIC	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
SUBSTANCE ABUSE	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
** PSYCHIATRIC	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
SUBSTANCE ABUSE	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANS PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY

\SA NETWORK
SPITAL

-MH\SA NETWORK
PITAL

OFFICIAL

JAN 06 2001

* CASES OF AN EMERGENCY ADMISSION OF A MANAGED CARE RECIPIENT IN A NON-NETWORK HOSPITAL, THE HOSPITAL MUST FOLLOW AUTHORIZATION PROCEDURES OUTLINED IN 106 CMR 450.125, SHALL BE REIMBURSED BY THE DIVISION'S MH\SA PROVIDER AT THE CURRENT ACUTE HOSPITAL RFA RATE FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES.

N CASES INVOLVING A TRANSFER TO OR FROM A DMH REPLACEMENT UNIT, SUBSTITUTE THE DMH CONTRACT RATE IN THE ABOVE MATRIX WHERE APPROPRIATE. A DMH RATE CAN APPLY IN UNSTANCES WHERE THE MATRIX INDICATES THE SERVICE IS NOT REIMBURSABLE. ALL OTHER RULES RELATED TO TRANSFERS WITHIN A HOSPITAL SHALL APPLY.

TRANSFERRING RULES- WITHIN A HOSPITAL

MANAGED CARE RECIPIENT

FROM : TRANSFERRING UNIT	TO: RECEIVING UNIT: MED SURG	** PSYCH	SUB\ABUSE
MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE
** PSYCHIATRIC	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE
SUBSTANCE ABUSE	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE

FROM : TRANSFERRING UNIT	TO: RECEIVING UNIT: MED SURG	** PSYCH	SUB\ABUSE
MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE
** PSYCHIATRIC	TRANSFERRING UNIT:* NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING & RECEIVING UNITS: NOT REIMBURSABLE
SUBSTANCE ABUSE	TRANSFERRING UNIT:* NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING & RECEIVING UNITS: NOT REIMBURSABLE

NON-MANAGED CARE RECIPIENT

FROM : TRANSFERRING UNIT	TO: RECEIVING UNIT: MED SURG	** PSYCH	SUB\ABUSE
MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
** PSYCHIATRIC	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
SUBSTANCE ABUSE	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY

FROM : TRANSFERRING UNIT	TO: RECEIVING UNIT: MED SURG	** PSYCH	SUB\ABUSE
MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
** PSYCHIATRIC	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
SUBSTANCE ABUSE	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANS PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY

\SA NETWORK
SPITAL

I-MH\SA NETWORK
SPITAL

N CASES OF AN EMERGENCY ADMISSION OF A MANAGED CARE RECIPIENT IN A NON-NETWORK HOSPITAL, THE HOSPITAL MUST FOLLOW AUTHORIZATION PROCEDURES OUTLINED IN 106 CMR 450.125, SHALL BE REIMBURSED BY THE DIVISION'S MH\SA PROVIDER AT THE CURRENT ACUTE HOSPITAL RFA RATE FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES.

IN CASES INVOLVING A TRANSFER TO OR FROM A DMH REPLACEMENT UNIT, SUBSTITUTE THE DMH CONTRACT RATE IN THE ABOVE MATRIX WHERE APPROPRIATE. A DMH RATE CAN APPLY IN CUMSTANCES WHERE THE MATRIX INDICATES THE SERVICE IS NOT REIMBURSABLE. ALL OTHER RULES RELATED TO TRANSFERS WITHIN A HOSPITAL SHALL APPLY.

TRANSFERRING RULES- BETWEEN TWO HOSPITALS
FOR NON-MANAGED CARE RECIPIENTS ONLY

M : NSFERRING HOSPITAL	TO : RECEIVING HOSPITAL	MH\SA NETWORK OR NON-MH\SA NETWORK HOSPITAL MED SURG	** PSYCH	SUB\ABUSE
SA NETWORK NON-MH\SA OSPITAL	MED\SURG	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: PSYCH PER DIEM	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD
	** PSYCHIATRIC	TRANSFERRING HOSP: PSYCH PER DIEM RECEIVING HOSP: SPAD	TRANSFERRING HOSP: PSYCH PER DIEM RECEIVING HOSP: PSYCH PER DIEM	TRANSFERRING HOSP: PSYCH PER DIEM RECEIVING HOSP: SPAD
	SUBSTANCE ABUSE	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: PSYCH PER DIEM	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD

I CASES OF AN EMERGENCY ADMISSION OF A MANAGED CARE RECIPIENT IN A NON-NETWORK HOSPITAL,THE HOSPITAL MUST FOLLOW AUTHORIZATION PROCEDURES OUTLINED IN 106 CMR 450.125, SHALL BE REIMBURSED BY THE DIVISION'S MH\SA PROVIDER AT THE CURRENT ACUTE HOSPITAL RFA RATE FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES.

N CASES INVOLVING A TRANSFER TO OR FROM A DMH REPLACEMENT UNIT, SUBSTITUTE THE DMH CONTRACT RATE IN THE ABOVE MATRIX WHEN APPROPRIATE. A DMH RATE CAN APPLY IN UMSTANCES WHERE THE MATRIX INDICATES THE SERVICE IS NOT REIMBURSABLE. ALL OTHER RULES RELATED TO TRANSFERS BETWEEN TWO HOSPITALS SHALL APPLY.

TN 98-12
STATE PLAN AMENDMENT EXHIBITS
INPATIENT ACUTE HOSPITAL

Exhibit 4:
114.1 CMR 36.05(2)(k)
114.1 CMR 36.07

and then producing a cumulative frequency of discharges. The casemix adjusted capital efficiency standard is established at the casemix adjusted capital cost per discharge corresponding to the median discharge. The capital efficiency standard is updated for inflation between FY93 and FY94 by a factor of 3.01%, by a factor of 2.80% for inflation between FY94 and FY95, by a factor of 1.80% for inflation between FY95 and FY96, by a factor of 1.0% for inflation between FY96 and FY97, and by a factor of 0.8% for inflation between FY98 and FY99. The 1.8%, 1.0%, and 0.8% capital update factors are taken from annual HCFA regulations and are used by HCFA to update the capital payments made by Medicare.

Hospitals with unique circumstances, as defined in 114.1 CMR 36.05(7) are excluded from the calculation of the efficiency standard.

(g) Admissions involving one-day length of stay following outpatient surgical services. If a patient who requires hospital inpatient services is admitted for a one-day stay following outpatient surgery, the hospital shall be paid at the transfer per diem rate established according to 114.1 CMR 36.05(4) instead of at the hospital's standard payment amount per discharge.

(h) Payments for newly eligible recipients or in the event of exhaustion of other insurance. When a patient becomes newly Medicaid eligible or if they become eligible because other insurance benefits have been exhausted after the date of admission and prior to the date of discharge, the acute stay is paid using the transfer *per diem* payment, established according to 114.1 CMR 36.05(4), up to the hospital-specific per discharge amount. If the patient is at administrative day status (AD), payment will be made at the AD *per diem*, as established in 114.1 CMR 36.05(5).

(i) Rate of payment for physician services. For physician services provided by hospital-based physicians to Medicaid inpatients, the hospital is reimbursed in accordance with, and subject to, the Physician Regulations at 130 CMR 433.000 *et seq*. Such reimbursement is at the lower of the fee in the most current promulgation of the Division of Health Care Finance and Policy fees as established in 114.3 CMR 16.00, 17.00, 18.00 and 20.00, or the hospital's usual and customary charge.

Hospitals are reimbursed for such physician services only if the hospital-based physician took an active patient care role, as opposed to a supervisory role, in providing the inpatient service(s) on the billed date(s) of service. Physician services provided by residents and interns are reimbursed through the DME portion of the SPAD, and, as such, are not reimbursable separately.

Hospitals are not reimbursed for inpatient physician services provided by community-based physicians.

(j) Rates of payment for Inpatient Hospital Services Provided to Medicaid Recipients Enrolled in Managed Care Organizations (MCOs).

1. The methodology described in 114.1 CMR 36.05 applies to rates for Medicaid recipients enrolled in Managed Care Organizations (MCOs) with the exception of the following.

a. A separate casemix index is calculated for disabled recipients and applied to the statewide standard payment amount per discharge. This results in a distinct and separate per discharge rate, outlier rate and transfer rate which applies to disabled recipients enrolled in MCOs. Disabled recipients enrolled in the Medicaid program are defined as those recipients eligible under S.S.I. and Medicaid Disability Assistance (categories of assistance 03 and 07).

b. A separate casemix index is calculated for non-disabled recipients (all other categories of assistance) and applied to the statewide standard payment amount. This results in a distinct and separate per discharge rate, outlier rate and transfer rate which applies to all Medicaid recipients enrolled in MCOs, except disabled recipients.

2. If an MCO offers to pay a hospital a rate equivalent to the applicable rate of payment established for that hospital by 114.1 CMR 36.05 for services to the MCO's Medicaid enrollees, that hospital is required to accept the MCO's rate offer as payment in full for those enrollees. This requirement does not preclude an MCO from choosing to pay any hospital at a rate higher or lower than the applicable rate of payment established for that hospital by 114.1 CMR 36.05 for services to the MCO's Medicaid enrollees.

(k) Maternity/Newborn Rates Delivery related maternity cases are paid on the standard payment amount per discharge (SPAD) basis with one SPAD paid for the mother and one SPAD paid for the newborn. The rate includes payment for all services except physician services provided in conjunction with a maternity stay, including but not limited to follow-up home visits provided as incentives for short delivery stays. There are no additional payments to the hospitals or to other entities, such as Visiting Nurse Associations or home health

agencies, for providing services in collaboration with the hospital. Hospitals are required to apply any and all maternity and newborn policies and programs equally to all patients, regardless of payer.

(3) Outlier rates of payments.

(a) Eligibility. An outlier *per diem* payment is added to the standard payment amount per discharge for a particular patient if all of the following conditions are met:

1. the length of stay exceeds 20 cumulative acute days (not including days in a distinct part psychiatric unit);
2. the hospital has fulfilled its discharge planning duties as required by 130 CMR (Division of Medical Assistance regulations);
3. the patient continues to need acute level care and is therefore not on administrative day status on any day for which outlier payment is claimed;
4. the patient is not a patient in a distinct part psychiatric unit on any day for which an outlier payment is claimed.

(b) The outlier *per diem* payment amount is equal to 55% of the statewide standard payment amount per day multiplied by the hospital's wage area index and Medicaid casemix index, plus a *per diem* payment for the hospital's pass-through costs, direct medical education, and reasonable capital costs. The statewide standard payment amount per day is equal to the statewide standard payment amount per discharge divided by the statewide average FY95 all payer length of stay. The pass-through, direct medical education and reasonable capital cost *per diem* payments are equal to the per discharge amount for each of the components divided by the hospital's Medicaid length of stay.

(c) Pediatric Outlier Payment. In accordance with 42 U.S.C. 1396a(s), an annual pediatric outlier adjustment is made to acute care hospitals providing medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay for children greater than one year of age and less than six years of age. Only hospitals that meet the Basic Federally-Mandated Disproportionate Share eligibility per 114.1 CMR 36.07(3) are eligible for the pediatric outlier payment. The Pediatric Outlier Payment is calculated using the data and methodology as follows:

1. Data Source. The prior year's claims data residing on the Division of Medical Assistance Massachusetts Medicaid Information System is used to determine exceptionally high costs and exceptionally long lengths of stay.
2. Eligibility is determined by the Division as follows:

a. Exceptionally long lengths of stay: First, calculate a statewide weighted average Medicaid inpatient length of stay. This is determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of total discharges for all acute care hospitals in the state. Second, calculate the statewide weighted standard deviation for Medicaid inpatient length of stay. Third, multiply the statewide weighted standard deviation for Medicaid inpatient length of stay by two and add that amount to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold Medicaid exceptionally long length of stay.

b. Exceptionally high cost. Exceptionally high cost is calculated for hospitals providing services to children greater than one year of age and less than six years of age by the Division as follows:

1. First, calculate the average cost per Medicaid inpatient discharge for each hospital.
2. Second, calculate the standard deviation for the cost per Medicaid inpatient discharge for each hospital.
3. Third, multiply the hospital's standard deviation for the cost per Medicaid inpatient discharge by two and add to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each hospital's threshold Medicaid exceptionally high cost.

c. Eligibility for a Pediatric Outlier Payment. For hospitals providing services to children greater than one year of age and under six years of age, the Division calculates the following:

1. the average Medicaid inpatient length of stay involving children greater than one year of age and less than six years of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in 114.1 CMR 36.05(3)(c)2.a., then the hospital is eligible for a Pediatric Outlier Payment.

2. the cost per inpatient Medicaid case involving children greater than one year of age and less than six years of age. If this hospital-specific Medicaid inpatient cost equals or exceeds the threshold defined in 114.1 CMR 36.05(3)(c)2.b., then the hospital is eligible for a Pediatric Outlier Payment.

3. Payment to Hospitals. Hospitals qualifying for an outlier adjustment in the payment amount pursuant to 114.1 CMR 36.05, receive 1/2% of the total funds allocated for payment to acute hospitals under 114.1 CMR 36.07(3)(e). The total funds allocated for payment to acute hospitals under 114.1 CMR 36.07(3)(e) are reduced by the payment amount under 114.1 CMR 36.05(3)(c).

(d) Infant Outlier Payment In accordance with 42 U.S.C. 1396a(s), an annual infant outlier payment adjustment is made to hospitals providing medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay for infants under one year of age. The Infant Outlier Payment is calculated using the data and methodology as follows:

1. Data Source. The prior year's claims data residing on the Division of Medical Assistance Massachusetts Medicaid Information System is used to determine exceptionally high costs and exceptionally long lengths of stay.

2. Eligibility is determined by the Division as follows:

a. Exceptionally Long Lengths of Stay: The statewide weighted average Medicaid inpatient length of stay is determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of total discharges for all acute care hospitals in the state. The statewide weighted standard deviation for Medicaid inpatient length of stay is also calculated. The statewide weighted standard deviation for the Medicaid inpatient length of stay is multiplied by two, and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold figure for Medicaid exceptionally long length of stay.

b. Exceptionally High Cost is calculated for hospitals providing services to infants under one year of age by the Division as follows:

1. First, the average cost per Medicaid inpatient case for each hospital is calculated;

2. Second, the standard deviation for the cost per Medicaid inpatient case for each hospital is calculated;

3. Third, multiply the hospital's standard deviation for the cost per Medicaid inpatient discharge by two, and add that amount to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each hospital's threshold Medicaid exceptionally high cost.

c. For each hospital providing services to infants under one year of age, the Division determines first, the average Medicaid inpatient length of stay involving individuals under one year of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in 114.1 CMR 36.05(3)(d)2.a., then the hospital is eligible for an infant outlier payment.

Second, the cost per inpatient Medicaid case involving infants under one year of age is calculated. If a hospital has a Medicaid inpatient case with a cost which equals or exceeds the hospital's own threshold defined in 114.1 CMR 36.05(3)(d)2.b. above, then the hospital is eligible for an infant outlier payment.

d. Payment to Hospitals. Annually, each hospital that qualifies for an outlier adjustment receives an equal portion of $50,000. For example, if two hospitals qualify for an outlier adjustment, each receives $25,000.

(4) Rates of payments for transfer patients. The text and matrices contained in 114.1 CMR 36.05(4) set forth the payment rates applicable to transferred patients.

(a) Transfers between hospitals.

1. In general, payments for patients transferred from one acute hospital to another will be made on a transfer *per diem* basis, capped at the per discharge payment amount, for the hospital that is transferring the patient.

2. The transfer *per diem* payment amount is equal to the statewide standard payment amount per day, multiplied by the transferring hospital's Medicaid casemix index derived from paid claims between June 1, 1997 and May 31, 1998 and wage area index, plus pass-through, direct medical education, and capital *per diem* payments. The standard payment amount per

(22) Therapy Services

(a) Hospitals are reimbursed for physical, occupational, or speech/language therapy services according to both the Therapist Regulations in 130 CMR 432.000 and the cost to charge ratio or the hospital's usual and customary charges, whichever is lower. Therapy services provided the day before, the day of, and/or the day after a significant procedure are reimbursed according to the APG significant procedure group, as specified in 114.1 CMR 36.06(5).

(23) Off-site Radiation and Oncology Treatment Centers Hospitals that provide radiation and oncology treatment services through an Off-Site Radiation and Oncology Treatment Center will be reimbursed according to the lower of the Medicarefee schedule or the hospital's usual and customary charge. These rates represent payment in full for services and the hospital is not entitled to any additional reimbursement (e.g. clinic visit payments, APGs, physician payments).

(24) Outpatient Reimbursement for Non-profit acute care teaching hospitals affiliated with a Commonwealth Owned University Medical School.

(a) Effective April 1, 1998 and subject to 114.1 CMR 36.06(24)(b), the payment amount for outpatient, emergency department, and hospital licensed health center services at non-profit acute care teaching hospitals affiliated with a Commonwealth owned university medical school will be calculated as follows. The data used for this payment will be from the most recent submission of the hospital's or predecessor hospitals' DHCFP-403 reports.

The hospital's total outpatient charges are multiplied by the hospital's overall outpatient cost to charge ratio (the hospital's outpatient cost to charge ratio is calculated using the DHCFP-403 total outpatient costs located on schedule II, column 10, line 114 as the numerator and total outpatient charges located on schedule II, column 11, line 114 as the denominator) in order to compute the total outpatient costs. The total outpatient costs are then multiplied by the Medicaid outpatient utilization factor (this factor is calculated by dividing the total Medicaid outpatient charges by the total hospital outpatient charges) in order to calculate Medicaid outpatient costs. Medicaid outpatient costs are then multiplied by the inflation rates for those years between the year of the cost report and the current rate year.

(b) Any payment amount related to additional allowable costs in excess of amounts which would otherwise be due any non-profit acute care hospital affiliated with a Commonwealth owned university medical school pursuant to 114.1 CMR 36.06 is subject to compliance with specific legislative appropriation requiring an intergovernmental funds transfer and availability of federal financial participation.

36.07: Disproportionate Share Payment Adjustments

(1) Overview:

(a) Applicability. The Medicaid program assists hospitals that carry a disproportionate financial burden of caring for the uninsured and publicly insured persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid makes an additional payment adjustment above the rates established under 114.1 CMR 36.05 and 114.1 CMR 36.06 to hospitals which qualify for such an adjustment under any one or more of the following classifications. Medicaid payment adjustments for disproportionate share hospitals are a source of funding for allowable uncompensated care costs.

(b) Eligibility. Only hospitals that have an executed contract with the Division of Medical Assistance are eligible for disproportionate share payments. Medicaid participating hospitals may qualify for adjustments and may receive them at any time throughout the year. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating those adjustments are described in 114.1 CMR 36.07. When hospitals apply to participate in the Medicaid program, their eligibility and the amount of their adjustment is determined. As new hospitals apply to become Medicaid providers, they may qualify for adjustments if they meet the criteria under one or more of the following disproportionate share hospital (DSH) classifications (114.1 CMR 36.07). If a hospital's Medicaid contract is terminated, any adjustment is prorated for the portion of the year during which it had a contract, the remaining funds it would have received are apportioned to remaining eligible hospitals. This means that some disproportionate share adjustments may require recalculation. Hospitals are informed if an adjustment amount changes due to reapportionment among the qualified group and told how overpayments or underpayments by the Division of Medical Assistance are handled at that time. To qualify for a DSH payment adjustment under any classification within 114.1 CMR 36.07, a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. § 1396r-4(d) or qualify for the

exemption described at 42 U.S.C. § 1396r-4(d)(2). In addition, to qualify for a disproportionate share payment adjustment under 114.1 CMR 36.07 a hospital must have a Medicaid inpatient utilization rate, calculated by dividing Medicaid patient days by total days, of not less than 1%. Effective October 1, 1995 the total amount of DSH payment adjustments awarded to a particular hospital under 114.1 CMR 36.07 cannot exceed the costs incurred during the year by the hospital for furnishing hospital services to individuals who are either eligible for medical assistance or have no health insurance or other source of third party coverage less payments received by the hospital for medical assistance and from uninsured patients, and as provided at 42 U.S.C. §-1396r-4(g).

(2) High Public Payer Hospital Disproportionate Share Adjustment:

(a) Eligibility. Hospitals determined eligible for disproportionate share status pursuant to 114.1 CMR 36.04 are eligible for this adjustment.

(b) Calculation of Adjustment.

1. The Division of Medical Assistance allocates $11.7 million for this payment adjustment.
2. The Division then calculates for each eligible hospital the ratio of its allowable free care charges, as defined in M.G.L. c. 118G, to total charges. The Division will obtain free care charge data from the hospitals UC-Form filings, on a fiscal year basis consistent with the data cited in 114.1 CMR 36.04(2)(a).
3. The Division then ranks the eligible hospitals from highest to lowest by the ratios of allowable free care to total charges determined in 114.1 CMR 36.07(2)(b)2.
4. The Division then determines the 75th percentile of the ratios determined in 114.1 CMR 36.07(2)(b)2.
5. Hospitals who meet or exceed the 75th percentile qualify for a High Public Payer Hospital Adjustment. The Division multiplies each qualifying hospital's allowable free care charges by the hospital's most recent cost to charge ratio, as calculated pursuant to 114.6 CMR 11.04 to determine allowable free care costs.
6. The Division then determines the sum of the amounts determined in 114.1 CMR 36.07(2)(b)5. for all hospitals that qualify for a High Public Payer adjustment.
7. Each eligible hospital's High Public Payer Hospitals adjustment is equal the amount allocated in 114.1 CMR 36.07(2)(b)1. multiplied by the amount determined in 114.1 CMR 36.07(2)(b)5. and divided by the amount determined in 114.1 CMR 36.07(2)(b)6.

(3) Basic Federally - Mandated Disproportionate Share Adjustment

(a). The Division determines a federally-mandated Medicaid disproportionate share adjustment for all eligible hospitals, using the data and methodology described below. The Division uses the following data sources in its determination of the federally-mandated Medicaid disproportionate share adjustment, unless the specified data source is unavailable. If the specified data source is unavailable, then the Division determines and uses the best alternative data source.

1. The Division uses free care charge data from the prior year filing of the Division's uncompensated care reporting form..
2. The prior year RSC-403 report is used to determine Medicaid days, total days, Medicaid inpatient net revenues, total inpatient charges, and the state and/or local cash subsidy.

(b). The Division calculates a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of acute care hospitals for the federally-mandated disproportionate share adjustment. The Division determines such threshold as follows:

1. First, calculate the statewide weighted average Medicaid inpatient utilization rate. This is determined by dividing the sum of Medicaid inpatient days for all acute care hospitals in the state by the sum of total inpatient days for all acute care hospitals in the state.
2. Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics.
3. Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide average Medicaid inpatient utilization rate. The sum of these two numbers is the threshold Medicaid inpatient utilization rate.
4. The Division then calculates each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)3., then the hospital is eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

(c). The Division then calculates each hospital's low-income utilization rate as follows:

1. First, calculate the Medicaid and subsidy share of gross revenues according to the following formula:

$$\frac{\text{Medicaid gross revenues + state and local government cash subsidies}}{\text{Total revenues + state and local government cash subsidies}}$$

2. Second, calculate the free care percentage of total inpatient charges by dividing the inpatient share of free care charges less the portion of state and local government cash subsidies for inpatient services by total inpatient charges.

3. Third, compute the low-income utilization rate by adding the Medicaid and subsidy share of total revenues calculated pursuant to 114.1 CMR 36.07(3)(c)1. to the free care percentage of total inpatient charges calculated pursuant to 114.1 CMR 36.07(3)(c)2. If the low-income utilization rate exceeds 25%, the hospital is eligible for the federally-mandated disproportionate share adjustment under the low-income utilization rate method.

(d). Payment Methodology. The payment under the federally-mandated disproportionate share adjustment requirement is calculated as follows:

1. For each hospital deemed eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method established in 114.1 CMR 36.07(3), the Division divides the hospital's Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)4. by the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)3. The ratio resulting from such division is the federally-mandated Medicaid disproportionate share ratio.

2. For each hospital deemed eligible for the basic federally mandated Medicaid disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Division divides the hospital's low-income utilization rate by 25%. The ratio resulting from such division is the federally-mandated Medicaid disproportionate share ratio.

3. The Division then determines, for the group of all eligible hospitals, the sum of federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.07(3)(d)1. and 114.1 CMR 36.07(3)(d)2.

4. The Division then calculates a minimum payment by dividing the amount of funds allocated pursuant to 114.1 CMR 36.07(3)(e). by the sum of the federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.07(3)(d)3.

5. The Division then multiplies the minimum payment by the federally-mandated Medicaid disproportionate share ratio established for each hospital pursuant to 114.1 CMR 36.07(3)(d)1. and 2. The product of such multiplication is the payment under the federally-mandated disproportionate share adjustment requirement. This payment ensures that each hospital's utilization rate exceeds one standard deviation above the mean, in accordance with 42 U.S.C. § 1396r-4.

(e) The total amount of funds allocated for payment to acute care hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement is $200,000 per year. These amounts are paid by the Division of Medical Assistance, and distributed among the eligible hospitals as determined pursuant to 114.1 CMR 36.07(3)(d)5.

(4) Disproportionate Share Adjustment for Safety Net Providers. The Division determines a disproportionate share safety net adjustment factor for all eligible hospitals, using the data and methodology described in 114.1 CMR 36.07(4).

(a). Data Sources. The Division uses free care charge data from the prior year's filing of the Division's UC-9x report and total charges from the DHCFP-403. If the specified data source is unavailable, then the Division determines and uses the best alternative data source.

(b) Eligibility of Disproportionate Share Hospitals for the Safety Net Provider Adjustment. The disproportionate share adjustment for safety net providers is a payment for hospitals which meet the following criteria:

1. is a public hospital or a public service hospital as defined in 114.1 CMR 36.02.;

2. has a volume of Medicaid and free care charges in FY93, or for any new hospital, in the base year as determined by the Division of Health Care Finance and Policy which is at least 15% of its total charges;

3. is an essential safety net provider in its service area, as demonstrated by delivery of services to populations with special needs including persons with AIDS, trauma victims, high-risk neonates, or indigent or uninsured patients;